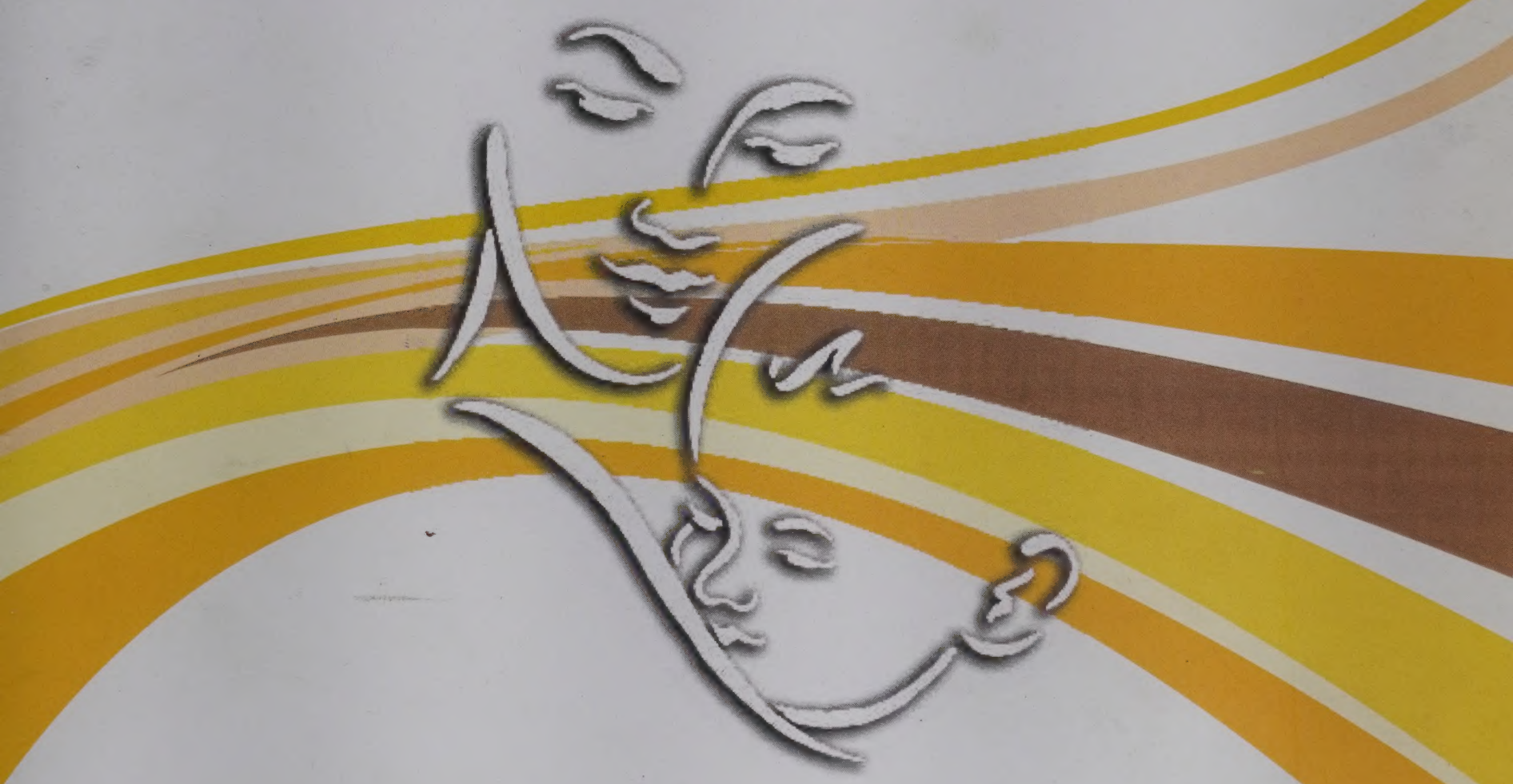
Update on the
ASHA programme

Progress Made and Challenges Faced



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Section I: Introduction

Community Processes under NRHM

One of the key components of the "architectural correction" envisaged under the NRHM is to strengthen community participation in all health programmes. Community processes are not to be confined to the community as beneficiaries. The community is seen as playing an active role in the design, implementation and monitoring of health programmes.

The major schemes through which community processes are strengthened are :

a. The ASHA programme.

b. The Village Health and Sanitation Committee.

c. The Un-tied fund provided to the sub-center and the VHSC and the space provided for public participation in making decisions.

d. The Rogi Kalyan Samitis (RKS) (or Hospital development committees) as a vehicle for public participation in facility management and the provision of un-tied funds for this purpose.

e. The district health societies and the district health planning process.

f. The "Community Monitoring" programme.

g. The involvement of NGOs in the mother NGO programme and in public-private partnerships of different sorts.

Of the community based programmes the flagship programme, NRHM's most well known and talked about face, is undoubtedly the ASHA programme. All reports and evaluations show that these schemes, especially ASHA programme, appear to be making a positive impact. However most assessments also show that there are significant gaps in the implementation of each of these programmes in the states and some process of active support to address these gaps is essential. The ASHA programme in particular is a multi faced complex, and a common sense approach underestimates the technical inputs that are involved in design and implementation of these programmes.

This update on the progress of ASHA programme draws upon both the data from the programme monitoring center and from numerous evaluations and appraisals to create a picture of the progress of the ASHA programme and the challenges that the programme faces. It then goes on to discuss a few key technical issues in the form of a section on FAQs and concludes with a brief section on how to access and use technical assistance to improve the programme.

Going by national and international experience, community health worker programmes have the potential to make a significant, if not massive, positive contribution to community health and awareness and to impact favourably on major MDG indicators like child survival. There is a need therefore to strengthen the ASHA programme and other communitisation initiatives so that much greater outcomes are realized.

Section II: Progress of ASHA programme:

The progress of the ASHA programme would be discussed in this section in four heads. First is the extent of selection and density of ASHAs deployed in each state. The second is the progress of training programmes. The third is the status of support structures and the fourth is on drug refill and incentives. States and Uts are categorised into four groups. First in the poor health performing 8 northern states. The second group is the eight north eastern states. The third is all the remaining states and the last group is the union territories.

Table 1: Status of selection and density of ASHAs

Table 1.A. High Focused States (excluding NE, J & K and Himachal Pradesh)

State Name	Proposed No. of ASHAs	Number of ASHA selected	%	Basis of numbers (Figure in bracket gives actual population ratio, where population ratio is calculated based on year 2001 rural population)
Bihar	87,135	69,246	79.46	One per 1000 population (1:853 population)
Chhattisgarh	54,000	55,000	100	One per habitation. Known as Mitanins. Funding however is equivalent to no. of Anganwadis i.e. 29347 (1:303 population)
Jharkhand	40,788	40,788	100	Known as Sahiya One per 500 population (1:514 population)
MP	62,253	43,038	69	Due to increase from 1 ASHA per 1000 population to 1 per anganwadi center (AWC) in the view of dispersed habitations. (1:713 population)
Orissa	34,324	34,252	99.8	One per AWC (1:911 population)
Rajasthan	48,372	42,385	87.62	Known as ASHA Sahiyogini One per AWC (1:895 population)
UP	1,35,832	1,35,522	99	One per thousand population (1:969 population)
Uttarakhand	9,923	9,873	99.4	One per Anganwadi centre (1:635 population)
Total	**4,47,974**	**4,04,451**	**90.28%**	

Table 1.B. Selection and density of ASHAs in North East states

State Name	Proposed No. of ASHAs	Number of ASHA selected	%	Basis of numbers
Assam	26,247	26,225	99.91	One per revenue village (1:845 population)
Arunachal Pradesh	3,862	3,545	91.80	One per habitation (1:225 population)
Manipur	4,242	3,878	91.41	One per revenue village. Now increased as per terrain (1:375 population)
Meghalaya	6,258	6,258	100	One per revenue village (1:298 population)
Mizoram	943	943	100	Mix of – one per revenue village and habitation (1:475 population)
Nagaland	1,700	1,700	100	One per village council (1:969 population)
Sikkim	636	636	100	One per habitation (1:756 population)
Tripura	7,357	7,119	96.76	One per AWC (1:360 population)
Total	**51,245**	**50,304**	**98.16%**	

Table 1.C. Selection and density of ASHAS in Other states

State Name	Proposed No. of ASHAs	Number of ASHA selected	%	Basis of numbers
Andhra Pradesh	70,700	70,700	100	1:784 population
Delhi	5,400	2,266	41.96	Only for bastees/slums One per 1000 population
Gujarat	31,438	25,861	82.26	Initially for tribal area, now increased to whole State (1:1010 population)
Haryana	14,000	14,000	100	1:1073 population
Himachal Pradesh	–	–	–	No ASHA in place. State has proposed for ASHAs in 09-10 PIP
J & K	9,764	9,500	97.30	1:718 population
Karnataka	39,000	39,000	100	1:461 population
Kerala	32,854	30,501	92.83	1:718 population
Maharashtra	8,914	8,765	98.32	Currently restricted to tribal area. Proposed to expand in other non-tribal area
Punjab	17,766	17,056	96	1:906 population
Tamil Nadu	6,850	2,650	38.68	Decision to start ASHA scheme is only in current year
West Bengal	42,690	16,021	37.52	Prog. Initiated in 22 blocks of 14 districts. Now expanding to 235 blocks of 17 districts
Total	**2,79,376**	**2,36,320**	**84.58%**	

Table 1.D. Selection and density of ASHAs in Union Territories

State Name	Proposed No. of ASHAs	Number of ASHA selected	%	Basis of numbers
Andaman	100	65	65	1:1110 population
Dadra and Nagar Haveli	250	–	–	No data available (1:680 population)
Chandigarh	200	200	100	1:460 population
D & D	250	107	42.80	1:403 population
Lakshadweep	86	86	100	1:392 population
Pondicherry	–	–	–	No ASHA Scheme
Goa	–	–	–	No ASHA Scheme

As one can see from the above tables, high focus states except Bihar and MP has selected over 90% of proposed number of ASHAs. The lower figure in MP is as a result of a recent modification to one ASHA per Anganwadi centre (AWC) instead of previous one ASHA per thousand populations. In table 1 B-the north east the figures are even better with the entire process being complete and with much better densities as appropriate to the low population density.

Chhattisgarh has a widely dispersed population and had therefore opted for one Mitanin per habitation-a total of 54,000 habitations. This gives a ratio of one per just 300 population. This makes voluntarism much easier, but the flip side is that earnings would not be as high. GOI agreed to finance the programme using 29347 as the number of ASHAs–as this was the number of anganwadis in place. Since the state has never been able to completely spend even this allocation, this arrangement has been accepted.

In other states and union territories till the beginning of 2009, ASHAs were sanctioned only for tribal areas – which was less than 10% of the blocks. Since January 2009, the programme has been expanded to the whole nation. Some states have availed of this and others have not. It is worth noting that Tamilnadu and Himachal which had not opted for this scheme so far have done so this year–leaving only Goa and a couple of Union territories without the ASHA programme.

Quality of selection is an issue, but except in several districts of Uttar Pradesh and a few districts of Bihar the complaints are limited. Eventual outcomes are acceptable, even here it could be self-correcting as those ASHAs selected wrongly tend to drop out. Processes of selection have been different in West Bengal and Rajasthan but we have no evidence as to whether this was better or worse than anywhere else.

Progress in Training

Progress in Training has varied. As a rule most states have completed the fourth round of training and are on to the fifth. In other words, they have completed on an average 16 to 19 days of training. A few states are working on the sixth round of training. To put it in perspective, if we assume that selection in these states was completed by 2007 end, then states should have achieved 35 days of training by now (23 plus 12)-but no state is near this. This is understandable since systems are only now coming into place.

The frequency or periodicity of training has been poor everywhere. Some states have tried to cover this gap and catch up by one mega round in which three rounds of training were merged and delivered together. If this was done as a residential camp and with rigor it could have helped, but that does not seem to be evident.

Table 2: ASHA Training Status

Table 2.A. ASHA Training Status in High Focus States (excluding NE and J & K)

State Name	No. of ASHAs selected	Training Status						Remarks
		Number of ASHAs Trained in						
		Module 1	Module 2	Module 3	Module 4	%	Module 5	
Bihar	87,135	57,362			7,335	16		Combined training of Module 2 to 4
Chhattisgarh	29,347 (54,000)	29,347	29,347	29,347	29,347	100	29,347 (100%)	Actually 50,000+
Jharkhand	40,788	40,115	39,482	39,214	34,412	87		State TOT going on
MP	62,253	48,734	45,147	45,126	23,379	52		
Orissa	34,324	34,117	32,832	32,786	32,352	94.4	Ongoing	
Rajasthan	48,372	40,361		40,361	40,361	95		Combine training of Module 2 and 3
UP	1,35,832	1,29,056			1,09,443	92		Combined training of Module 2 to 4
Uttarakhand	9,923	9,873	9,873	9,873	9,873	100	8,411 (85.2%)	

Table 2.B. ASHA Training Status in North East states

State Name	No. of ASHAs selected	Training Status					
		Number of ASHAs Trained in					
		Module 1	Module 2	Module 3	Module 4	%	Module 5
Assam	26,247	26,225	26,225	26,225	26,225	100	Ongoing
Arunachal Pradesh	3,862	2,711	2,711	2,711	2,711	77.97	Ongoing
Manipur	3,878	3,225	3,225	3,000	3,000	77.35	Ongoing
Meghalaya	6,258	5,946	6,059	5,174	5,199	83	Ongoing
Mizoram	943	943	943	943	943	100	Ongoing
Nagaland	1,700	1,700	1,700	1,700	1,700	100	Ongoing
Sikkim	636	636	636	636	636	100	Ongoing
Tripura	7,357	6,961	6,767	6,348	6,228	87.48	Ongoing

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Table 2.C. ASHA Training Status in Other States

State Name	No. of ASHAs selected	Training Status						
		Number of ASHAs Trained in						Remarks
		Module 1	Module 2	Module 3	Module 4	%	Module 5	
Andhra Pradesh	70,700	70,700	70,700	70,700	70,700	100	100	23 days combined residential training
Delhi	5,400	2,266	2,266	2,266	2,266	100		
Gujarat	31,438	21,257	15,516	13,447	12,413	36.35		
Haryana	14,000	14,000	14,000	14,000	14,000	100		
J & K	9,764	9,500	8,930	8,930	8,930	94		
Karnataka	39,000	39,000	39,000	39,000	39,000	100		
Kerala	32,854	27,024	20,130	1,940	0			
Maharashtra	8,914	8,765	8,765	8,765	8,765	100		Module 5 State TOT going on
Punjab	17,766	13,797	0	0	0			
Tamil Nadu	6,850	0	0	0	0			
West Bengal	42,690	11,200	9,196	8,449	6,969	43.49	5,878	

The Progress in Support Structures

There are three critical support structures:

The first relates to the deployment of manpower for monitoring, hand holding and on the job training at all levels. At the state and district level it takes the form of programme management teams and/or resource centers. At the block level there is to be a coordinator for each block and at the sub-block level a facilitator for every 20 ASHAs. Progress on this score is shown in the tables below (3A to 3C).

The second support structure relates to the arrangement for procuring and distributing drug kits and the efficiency with which refill is organized. This too is reflected in the tables below.

The third support structure is the mechanisms for paying incentives on time. This has not been possible to capture and display in numerical data. Also though the information on what is proposed in each state, there exists poor clarity on what is actually delivered. This is therefore discussed in the subsequent sections but not as a part of the table.

One critical element of the support structure is the schedule of review meetings at each level, the indicators in use, the mechanisms of monitoring. This too is difficult to capture as tables and is discussed in subsequent sections.

Table 3. Progress in Support Structure

Table 3.A. Support Structures in High Focus states (excluding J & K)

Activity/Prog Status		Name of the States							
		Bihar	Chhattisgarh	Jharkhand	MP	Orissa	Rajasthan	UP	Uttarakhand
Support Structure	State level	+	++++	++	x	++	+++	x	++
	District level	x	++++	++	++	++++	+++	++++	++
	Block level	x	++++	++	x	++++	x	x	x
	Sector level	x	++++	x	x	x	x	x	x
Drug kit distribution		Not yet	100%	85.80%	100%	99.60%	75.63%	92%	100%
Drug kit refilling status		—	++	+	+++	+++	++	+	++

***Support Structure: ++++ = fully functional & effective, +++ = Functional & becoming effective, ++ = Institution made, not fully effective, + = Role assigned, but somewhat effective

***Drug kit refilling status: +++ = Good, ++ = Moderate, + = Poor

Table 3.B. Support Structures in North East States

Activity/Prog Status		Name of the States							
		Assam	Arunachal Pradesh	Manipur	Maghalaya	Mizoram	Nagaland	Sikkim	Tripura
Support Structure	State level	++++	++	++	++	++	++	++	++
	District level	++++	x	x	x	x	x	x	x
	Block level	++++	x	x	x	x	++	x	x
	Sector level	++++	x	x	x	x	x	x	x
Drug kit distribution		100%	47.39%	77.35%	98.75%	100%	100%	83.33%	100%
Drug kit refilling status		+++	—	++	—	++	+	+++	+++

Table 3.C. Support Structures in Other states

Activity/Prog Status		Name of the States										
		Andhra Pradesh	Delhi	Gujarat	Haryana	J & K	Karnataka	Kerala	Maharashtra	Punjab	Tamil Nadu	West Bengal
Support Structure	State level	x	x	x	x	x	x	x	+++	x	x	+++
	District level	x	x	x	x	x	x	x	+++	x	x	+++
	Block level	x	x	x	x	x	x	x	+++	x	x	+++
	Sector level	x	x	x	x	x	x	x	+++	x	x	x
Drug kit distribution		100%	100%	—	—	100%	—	27.70 %	92.76 %	80.89 %	—	Not yet distributed

Section III:Overview of evaluation findings regarding ASHA programme

Since the launch of NRHM, the ASHA programme has been the focus of several assessments, evaluations and research studies. The studies vary widely in terms of focus, methodology and quality. Most studies are localized, and even if they cover multiple states they only provide broad, overarching recommendations, which serve to highlight issues and identify potential paths to resolve these.

The main studies that we have referred to are the

a. Common Review Mission reports of 2007 and 2008- both the state specific reports and the national overview.

b. International Advisory Panel on NRHM.

c. Rapid Appraisal studies done by NIHFW in collaboration with a number of agencies.

d. JSY and ASHA in Rajasthan: Appraisal done by CORT: UNFPA sponsored.

e. Evaluation of ASHA in Andhra Pradesh: CHW, GoAP & IIHFW, AP.

f. Reports of Jan Swasthya Abhiyan and Center for Health and Social Justice.

g. Tour report and rapid appraisal reports of ASHA mentoring group members.

The ASHA programme is being implemented in varying socio political and institutional contexts and therefore extrapolation of findings from localized evaluations and prescribing common recommendations have limited utility. However, some common findings emerge and these need to be explored further.

Common to all review findings, however is that the ASHA is critical for improving the community processes component and in achieving increased coverage and impact of selected health indicators. The report of the Second Common Review Mission, November 2009, reports that "significant progress has been made in addressing many of the gaps as identified in the first Common Review Mission Report" (CRM). State level CRM reports, are unanimous in their appreciation of the work being contributed by ASHAs, the enthusiasm shown by the ASHAs and their potential". The effectiveness of the ASHA reported in several studies ranges from "verily being the wheels of the NRHM in the hinterland" to being "poorly functioning".

There is also unanimity that substantial improvements are required in the functioning of the ASHA programme. In most states, critical inputs that the ASHA programme needs from programme management has not been provided. Despite the obvious enthusiasm at the village level, the sustainability and effectiveness of the programme would be threatened if these are not attended to immediately.

Effectiveness of the ASHA

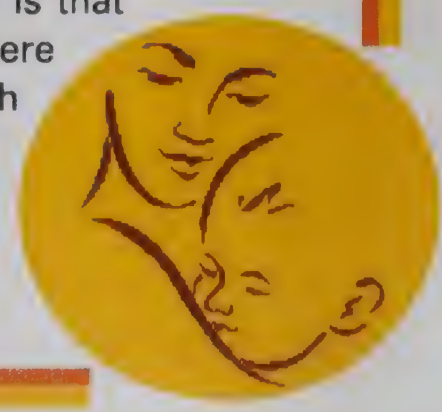
Core activities: Most evaluations show that a substantial proportion of ASHA's time is spent on two major activities: Promotion of Institutional delivery including accompanying pregnant women to institutions for delivery (JSY), and on Immunization. In some states ASHAs also spent significant time on family planning. Evidence of this effectiveness emerges both from what ASHAs report about their work and what community and beneficiaries of services for pregnancy and immunization report about ASHAs. The number of ASHAs who report that they were involved in counseling is above 90% in well performing states (98% in Andhra Pradesh, 83.8% in Orissa) to about 25% in the weak areas- but almost always this is the major work. The report from a sample of beneficiaries would be less – showing that all mothers were not being reached- but even here the range is about 80% reporting a positive promotion message from ASHA in the better performing states. Not surprisingly one study showed that those with home deliveries reported less contact with ASHA than those with institutional delivery. 83.2% of those with home delivery had not heard about ASHAs (Sahiyya) and 16.8% of those with institutional delivery had not heard about ASHA in a study from Jharkhand. (S.Haider et al3.) The pattern with immunization is also similar – but at a lower achievement average than for JSY. Though there is little systematic data on this, most assessments perceive immunization levels as positively influenced by ASHA support.

Other RCH functions: A recent study from Andhra Pradesh demonstrated that 13% of ASHA listed counseling and 17% liaison with AWW/Dai as their responsibilities. Studies from other states also show that the role of ASHA in counseling, and provision of postnatal care, is comparatively lower than for those functions which are incentive linked. There is little mention of involvement of ASHA, apart from the Mitanin programme in Chhatisgarh in issues of child health, particularly in addressing nutrition and newborn care. Uttarakhand also has an effort to reach out in newborn care.

Minor Illness Management: Where drug kits have been provided and reasonably replenished, treatment for minor illnesses also emerges as a major feature of ASHA's work profile. This is the pattern in Chhattisgarh, Assam and Orissa. Unfortunately, in many states the problem of refilling the drug kit is high. The IAP study, which is the most recent-from the three states of Rajasthan, MP and UP, shows that nearly 85% ASHA in their sample reported that they had received support from the ANM in refilling the drug kit. So perhaps there is some improvement in this area.

Malaria Control: In states like Orissa, Jharkhand and West Bengal there are special programmes being launched to place Rapid Deployment Kits (RDK) kits and drug depots with trained ASHAs and use this for early treatment. Early reports, largely anecdotal, are positive. Incentivisation of this has been done, but not very effectively. Where it is taking place, the effectiveness is due to quality of support.

VHSCs: A recently conducted study (September 2008-August 2009, in Uttar Pradesh, Madhya Pradesh, and Rajasthan) commissioned by the International Advisory panel (IAP) for NRHM, found that 69% of ASHA were involved with PRI/VHSC. The general trend is that VHSCs in these states are active only where ASHA is active. In the states where VHSCs are doing very well in terms of both utilization of funds and village health planning, like Chhattisgarh, the ASHA is the convener of the VHSC.



Social Inclusion: While there is little information on ASHA's ability to address social inclusion, qualitative evidence from a few studies is mixed- with some perceiving a caste bias, and others confident that this is clearly tilted in favour of weaker sections. But this issue needs to be explored further. The Andhra Pradesh study found that less than 50% of the ASHA's clientele belong to scheduled castes and scheduled tribes.

Training of ASHA

This is an area of concern in several aspects. Even where training is proceeding on schedule and where states report "completion of four modules, " the IAP study reports, that "Current training programmes for the ASHA are extremely inadequate, both in terms of the quality of training being imparted and the time allocated for the training". The CRM, 2008 also points out that the states of Bihar, Mizoram, and Uttar Pradesh are lagging behind in the training.

The relationship between training and support structures is clear and consistent. Where there is a full time team of district and block support in place-namely Orissa, Assam and Chhattisgarh, training objectives have been achieved. Where these are weak, they are not.

To cope with the inability to complete the four rounds of training many states are resorting to the strategy of combining the second, third and fourth rounds. If this was residential- the training would still be effective, at least for those ASHAs who attend. However, if it is non-residential then coming and going from village to block HQ sites daily for ten days – just does not happen. Even if it was residential the gap between the first round and this combined training and the fifth round is so long that the entire mobilisational effect is lost and retention of knowledge is weak.

Orissa and Assam have done 7+4+4+4 days of training whereas most other states have done 7+10. The training and programme outcomes clearly show the difference between these and other states.

Andhra has chosen a different model and that seems to work very well too. They have trained a number of ANMs and nurses to act as trainers and contracted out the entire training to an NGO. The training was for 25 days, residential and at the outset as an induction mode. After 6 months they further introduced two day rounds of refresher training. The sustainability of this approach without support structures remains to be seen.

Payment of Incentives

A third issue that the ASHA programme faces across the states is related to the payment of incentives. The IAP study notes that "Untimely payment of incentives to ASHA is serving as a huge disincentive for taking on the role that is expected of them. The presently followed system of paying the ASHAs is a lengthy process which is not only cumbersome, but very poorly implemented as well. The incentive amounts being paid currently are extremely meager." Other studies and the CRM highlight gaps in timely and complete payment of incentives to ASHA.

There are three issues that are debated on payment. Firstly, whether there should be a fixed monthly amount over and above which there is a performance based incentive. The consensus has been against it, albeit with some major dissenting views. One powerful reason against it is that where such fixed

payment has been available (out of state funds) there is no positive effect seen. The second is whether, the incentive based payment that is allowed is paid timely, efficiently and with dignity. This is a management challenge, but some states notably Orissa have shown it is possible to have such a system in place. Basically it requires a clear flow of funds, allocation of responsibilities, single window arrangement for the ASHA, and a system of monitoring to identify and solve the delayed payments.

Even Chhattisgarh which has done well in many other parameters is poor in this aspect. The third aspect is the menu of activities for which payment is possible and effective. Some states have shown innovation in this –but it is too early to know outcomes.

Support Systems for ASHA

The CRM notes that in Assam, Chhatisgarh, and Orissa which appear to be the exception, support systems have been established to ensure mentoring, support and monitoring of ASHA. For the rest of the states, establishing support mechanisms appears to be a challenge. The IAP study finds that "there were serious problems due to lack in management structures". The lack of support systems at state, district, block and ASHA level, greatly limits the potential of the ASHA programme and affects quality of its present coverage and reach. The favourable impact of support structures on the frequency, duration and outcomes of training have already been noted. However even on monitoring, support to areas with poor functionality, refilling drug kits, social mobilization etc- the lack of a support system hurts.

The main reluctance in establishing such a system seems to be the lack of will (why – to) or a combination of a lack of will and lack of confidence to be able to manage such an amorphous workforce. Underlying the lack of will is lack of conviction about ASHA and the role of community participation. And underlying the lack of confidence is a lack of clarity on "How – to do so".

ASHA resource centers are functional in Assam, Jharkhand ,Uttarakhand and now Rajasthan and management teams in Orissa. Chhattisgarh has the SHRC to play this role. Other states have to start this up and a long way to go to make it effective. ASHA mentoring groups are functional in all states-but few adminstrators have internalized the inherent need for bureaucracy to be guided by the best of civil society in theory and practice of community health worker programmes. The need for technical assistance is poorly appreciated, as most weaknesses are rather too readily attributed to inherent design problems of the ASHA programme, rather than remediable management errors.

Bihar

The strength of the Bihar programme is that the ASHA is still available and functional despite the very thin quality of support received. Main points of engagement and incentivisation of the ASHA are the Muskan program and the JSY.JSY incentives are paid through cash for ASHAs and by cheques for beneficiaries. JSY payments are delayed, sometimes by months but happening. Muskan has a complex system of payment according to achievement level of immunization. That is difficult to monitor and it is rather unrealistic to make the ASHA's payment dependent on a fixed level of achievement irrespective of baselines and supply side constraints. Local flexibility in interpretation has allowed the Muskaan to have some effectiveness.

The main weakness of the Bihar programme is the complete absence of a support structure at district level plus a weak choice of a state management structure. The PHED departments resource unit "Pranjal" knew too little about community health or scaling up approaches to be able to manage the state leadership role- and does not have the sense of urgency to meet the time schedules. Pranjal was asked to undertake ASHA training in November 2007 and it started work in February 2008. ASHA training was its first project. Its staff consists of one director, one deputy director and two consultants supported by UNICEF. The director and deputy directors are engineers with no past experience in health much less community health workers or health training. The consultants too have limited experience in this area. First round of ASHA training was done before Pranjal came to the scene and this was completed in six months. In the two years since Pranjal the second round of training– which is a combination of modules 2 to 4 , has reached 15,000 of the approximately 69125 ASHAs and even by their own plans will cover the state only by March 2010. The objectives was to reach this level of training by December 2008! And the state had to cover two more modules by 2010.Thus though the gap between two rounds of ASHA training should be only about three months, in Bihar it is more than two years!!!. Over 10 crores transferred in February for expenditure in 2008, is only about 15% spent by September 2009.

Clearly, it is time to change from Pranjal to an alternative state level arrangement. The alternative would be to set up the ASHA resource center at the state level and operationalise the scheme as envisaged under national guidelines. If a clear cut reversal of the Pranjal decision cannot be made and if it is not possible to recover the funds, it may be useful to empower the districts to go ahead with other rounds of ASHA training programmes, while in parallel hand-holding and supporting and persuading Pranjal to complete the second round commitment it has already made and which the state health society has paid for.

Chhattisgarh

The strength of the programme is its sustainability and its innovation. Seven years after inception the programme continues to flourish. A high level of skills are in place, there is a high degree of motivation and comprehensive support structures are in place for Mitanin Program. Mitanin help desks are in place in all the CHCs and in district hospitals. This programme has more of an activist character, on the basis of which the ASHA gets its name. There is also a conscious planning for the future. A conceptual workshop called the future of the Mitanin programme addresses

how planning over the next five years – so that there is a vision for-when the programme is 12 years old. The Mitanin programme – VHSC synergy is also excellent. Its weakness is its poor quality of facility support for the referred patient as human resources and minimum levels of functionality of facilities has been slow to improve. Payment of incentives is also weak, though this is not perceived as being a limiting factor. Mitanins could often be in competition with ANMs for Family Planning or DOTS incentives.

Jharkhand

NGOs are involved in Sahiya/ASHA selection through Village Health Committees and training of Sahiyas. Good training modules have been developed in the local contexts. Sahiyas are mostly linked with the local communities they represent instead of being seen as assistants to ANM. State TOT for Module V has been completed. Incentive payments for Sahiyas are made through cheques for JSY. Other incentives including Immunisation are paid through cash. Support structure is of intermediate status. A state level resource center was formed by outsourcing to an NGO-CINI, but not followed through with transfer of funds or empowering them. Subsequently this role reverted to the SPMU where it moved slowly. A district community mobiliser just has been hired, not yet fully in place. Block and sub-block arrangements are weak. Initially the plan was to provide block support exclusively through NGOs and 22 NGOs were selected. However there is dissatisfaction with their selection and their subsequent effectiveness and now the system wants to proceed largely with government appointments. Monthly meetings for Sahiyas are held at the Block PHC level.

Madhya Pradesh

ASHA are reported by the States to be knowledgeable about their roles and responsibilities. District level trainings are organized for ASHAs with resource persons available at the district level for these trainings. Incentive payment for ASHAs is made through cheques and cash both for JSY and Immunisation. Training on state TOT on Module V is to begin soon. However, IAP report states that " ASHAs do not appear to be active on the field. In Raisen district, Mandeep CHC, only 4 out of 45 deliveries were accompanied by ASHAs, In Abadaiduhaganj 10% of deliveries are accompanied by ASHAs. In Eichwar CHC in Sehore district, only 65 out of 249 deliveries in September were mobilized by ASHAs. A major issue is the state guidelines which make all mobilisers eligible for compensation diminishing incentives for ASHAs to be involved. Since dais have been around for a long time most women bring dais along. Functional relationship between ASHA, ANM and AWWs and dais are particularly a problem in Madhya Pradesh, out of proportion to what is seen in other states and this need to be addressed. The ASHA to VHSC link is weak though she has been positioned well, because of lack of capacity building and support.

The lack of an ASHA support structure at state or district levels and the lack of support at block level takes a heavy toll. The ASHA mentoring group has met twice and both times reiterated this- but the state would prefer to manage support with existing workforce. No explicit plans of montiroing are in place.

Orissa

ASHAs are found to be rooted in the community they serve for, highly motivated and knowledgeable about their roles and responsibilities. They play an effective role in nutrition and women's empowerment, and functional coordination with Self-help groups and AWWs. Timely replenishment of drug-kit, timely availability of incentives, integrated compensation package, use of e-banking for facilitation of incentive payments, monthly sector level review meetings for tracking of

incentives are successful innovations in the State. Recognition of their contributions through ASHA Awards, ASHA Day, and introduction of ASHA Help desk in 35 health institutions including district hospitals are some of the effective steps to strengthen ASHA program in the state. Rolling out of Module V is in progress. 42, 141, Gaon Kalyan Samitis(VHSC) are formed with ASHA as member secretary, with 34,132 Bank accounts opened and Funds transferred for 32614. Facilitation of key community processes such as, Gaon Kalyan Samities, PRIs involvement; Village Health & Nutrition Days are instrumental in creation of community participation. Facilitators are in place in state, district and block level. The main weaknesses are a lack of the sub-block facilitators and the lack of state specific planning to improve health outcomes further- the latter being a reflection on the lack of an ASHA resource center or group at the state level. But for all that, along with Assam, this is emerging as the role model of the ASHA programme and ASHA demonstration site for all national and international visitors.

Rajasthan

On paper Rajasthan programme has two advantages which to most other States are ideals to be attained. One of these is the complete integration with the ICDS programme and the other is the fixed monthly payment of almost Rs 950 to the ASHA- Rs 500 from the ICDS and Rs 450 from the health department. Surprisingly, programme managers there see the ICDS integration as a problem and the fixed payment as far from sustainable. There is also no easy methodology to test whether it is helping or not. Distributed command between departments is seen as a problem leading to poor ASHA contribution to JSY, family planning and immunization goals. Nor is there evidence that other roles are being attended to. Support structures have only recently (since June) been operationalised at state and district levels. Trainings are behind schedule and rather fragmented. Training on State TOT on Module V, will begin soon as part of 15 days compressed Module for 2,3,4 & 5. Incentive payments for ASHAs are made through cheques for JSY & Immunisation and other incentives are paid through cash. There is one independent assessment available- which is equivocal on critical issues. In some districts a health department alone model is being tried and there are plans to separate the ASHA role from the Sahyogini role.

Uttar Pradesh

The programme at the grassroots appears effective. However training has been slow and of limited effectiveness. The 2nd to the 4th modules were combined and delivered. 99 % of ASHAs trained in the first Round and as of now 92 % in the Second Round in a combined 2, 3 & 4 Module. Training on Module V needs to speed up. Effective functional relationships with ANM & AWWs need streamlining. A number of new initiatives such as ASHA Sammelan, ASHA Award, ASHA Quarterly Magazine, ASHA Identity Cards are facilitating ASHA programme in the state. Incentive payments for ASHAs are made through cheques for JSY and Immunisation. State level resource centers are not in position. District coordinators are in position. Block level facilitators are not in position. Monitoring guidelines issued but still to be made effective. Drug kits distribution started- but not yet reached all.

Uttarakhand

23 days of ASHA training has been completed including training on Module V. Drug kits distribution is complete for all ASHAs. Incentive payment for ASHAs is made through cheques for JSY and Immunisation. VHSCs are not functional. NGOs play a major role in support at the state as the ASHA resource center and at district and block levels. Support structures are in place. District ASHA resource centers are also functional and a reasonable programme of monitoring is in place. Independent assessments are not available, but overall performance is clearly above average.

Assam

It is one of the best performing states on this programme and has numerous strengths. Social mobilization is used well. There is a good support structure in place at all levels. Training is on schedule. Monitoring is moderate to good. ASHAs are mostly involved in JSY & Immunization services, but also play a major role in minor illness management. Popular weekly radio programme for ASHAs are useful. Module V Training is also nearing completion in Assam. Its challenges are to now focus the programme on more specific outcomes and build up skill levels of the ASHA on one or two areas – for example the management of malaria or management of the newborn and sick child etc. Rural IMR is a huge problem and more must be taken out of this well placed programme.

Other NE States (Arunachal Pradesh, Manipur, Meghalaya, Mizoram, Nagaland, Sikkim and Tripura)

In all the 7 States, ASHA programme is doing well. Since health department staff is essentially adequate in numbers, support is being provided by ANMs or other health workers who are assigned this role. There is no resource centre, but there is a full time 'Community Mobilization Facilitator' at State level. Block level facilitators are in place in Nagaland. Training of ASHAs up to Module-IV is completed in all 7 States, and the rolling out of ASHA Module V training is in progress.

- Integrated compensation package is in place in the states of Tripura and in Manipur.
- Monthly meetings are operational in all states except in Arunachal Pradesh and in Manipur
- ASHA Mentoring Group is functional in all states except in Meghalaya
- ASHA help desk as been set up in Doimukh CHC in Arunachal Pradesh
- Drug kit refilling is happening well in Assam, Sikkim and Tripura, moderate in Manipur and Mizoram, poor in Nagaland. There is no refilling of drug kits in Arunachal Pradesh and Meghalaya
- Incentives payment for ASHAs are made through cash in all the 7 States

Andhra Pradesh

One of the early programmes to start up, its 70,700 ASHAs are one of the best selected and trained- a total of 30 days residential induction training: 21 days residential induction and 7 days of field based training. Drug kit is distributed to all ASHAs with effective refilling system in place. No full time support staff but District Training Team is looking after the training part of ASHA and District Public Health Nursing officer is looking after the monitoring aspects of ASHA at District level. Monthly meeting of ASHAs is in place. Ranga Reddy district in Andhra Pradesh has been consistently on the top for the best performance records of ASHAs. Weakness seems to be no clear retraining plan, inadequate leverage of the programme for specific health goals, and weak monitoring and support system. So, it is a great start, but sustainance and effectiveness need to be studied in detail.

Delhi

2266 ASHAs have been selected as against a target of 5400 and VHSC has been formed in 182 urbanised villages.19 days training completed (Module IV) and drug kits distributed. Support structure and monitoring system said to be in place. No independent assessment is available.

Jammu and Kashmir

9500 ASHA (94%) selected and received training upto 19 days - Module IV stage. Drug kits and regular schedule of monitoring meetings in place. Payments are made by cheques. Support structures are weak. 6788 VHSC have been constituted

Kerala

30501 ASHA (93%) have been selected and 15 days training is completed. The State planned an interesting and different role but implementation seems to have been on national pattern: 88.6% has received training of Module I, 66% received training in Module II & 6.36 received training in Module III. Additional training is proposed before providing drug kits. 8450 ASHAs has received drug kits and another 14900 drug kits are in process. Lack of ARC is reflected in desire for innovation not being translated into action. ASHA is involved in JSY, immunization, DOTS, detection of pregnancy, Female Sterlization motivation, tabulated house hold survey, disease control programme, organising Ward Health & Nutrition days, Palliative care, active role in all activities of sub-centres etc.16009 Ward Health & Sanitation committee has been formed.

Maharashtra

8,765 ASHAs have been selected in tribal areas (Target 8,914 ASHAs) and 19 days training completed. 8131 ASHAs have received drug kits. Support structures in form of block facilitators and regular meetings and payments have been put in place – but there is no resource center at the state level. 36,842 VHSC have been formed. Programme is to be expanded to whole state.

Punjab

94% ASHAs have been selected but only 7 days training is completed. There is delay in translation of modules. No state specificities have been introduced and no support structures of any sort are in place. Drug kit have been distributed to those ASHAs who received training of Module I. 12661 VHSC have been formed.

Gujarat

82.26% ASHA have been selected and 19 days training reached though only 48% have covered upto module 4. Modules are available in Gujarati. Participation in Mamta Taruni & Mamta Diwas is a special feature. 16,860 VHSC have been formed.

Karnataka

39000 ASHA have been selected and an Andhra style 30 days training module has been followed. 27990 drug kits have been procured to ASHAs. State AMG has been formed but no support structures are in place. 23,026 VHSC have formed out of 27,683.

Haryana

14,000 ASHA have been selected and training is ongoing. Upto module IV has been achieved. Printing of training material is in process. ASHA Diary is put in place. No support structures or system of monitoring is there. VHSC have been formed in 6212 Village Panchayat.

West Bengal

13613 ASHAs have been selected and 9800 ASHA have completed refresher training. Drug Kit was distributed to 4699 ASHAs. Incentives exist for best performing ASHAs. Most ASHAs receive effectively a fixed amount. Immunisation coverage improvements have been noted. 20,000 Gram Unnayan Samiti have been formed which are playing the role of VHSC.

Tamilnadu

Programme is being initiated this year. 2650 ASHAs will be selected in pilot phase as per GOI guidelines and priorities will be given to dais, alternate vaccinator in Public Private Partnership (PPP). Selection will be extended to 42 blocks by further adding 4200 ASHAs. 25 days training proposed. VHSC has been formed in 12,618 Villagae Panchayat and 2540 Town Panchayats.

Section V: Frequently Asked Questions

Given below are a set of questions that have often been asked of NHSRC and to the ASHA mentoring group members during their visits. They also relate to many of the issues raised in the evaluations and the recommendations made.

A. What is the desired frequency and duration of training?

The recommendation of the National ASHA mentoring group is to try for 24 to 28 days per year. Below 12 days per year is completely sub-critical and would lead to a poor programme. This frequency of training acts to refresh her skills, and also acts as mobilization and monitoring strategy. The 12 days are preferably divided as three to four day rounds every 3 to 4 months. Such repeated training requires a good support team and a well supported training team made up of the support team plus others who would be available for the training days. One round of training from training of trainers to training of all ASHAs should be completed within a three month period, which means a large number of training camps happen in parallel. Ad hoc arrangements and charismatic senior trainers are good for one round of training but soon everyone gets back to their main work and the training programme languishes. This is what happened in many of the poor performing states.

B. What is the training plan after the fifth round of training?

- Obvious answer- the sixth round of training! And then the seventh round and so on. The states would make the next module appropriate to their needs. They would study a sample of ASHAs to understand what skills they have acquired. The first five modules was more of a general overview. Depending on state priorities and plans for community support the focus of ASHA's work can be decided. States with high rural infant mortality or with high incidence of malaria /kala-azar may want to focus the programme in making a visible impact on these issues. Community health workers are known to be most effective for these problems.

- Technical assistance for this would be needed. The state could arrange for it, or ask NHSRC to mobilize the agency or individuals who can assist the state in this task.

C. How does one improve quality of training?

- The single most important step is to have a well defined training team of 7 to 15 persons in place at the state level to train the district teams, another 5 to 7 persons at each district level to train block teams, and about 5 to 15 persons in each block level to train ASHAs. Not all the training team members can be full time trainers. At least half the trainers would be nurses or supervisors or health educators or even some doctors who would be made available only to attend the training of trainers session and to train three or four batches of ASHAs each. Ensure that the trainers do not feel themselves too senior to attend a training of trainers workshop and are not too junior to make an impression on their trainees.

- The next most important step of training quality is to make very good training material that is compulsory to transact as part of the

training programme-page by page. It could be with audio visual aids and interspersed with discussions and field visits but if the material is not rigorously followed- transmission loss would occur.

- The third most important step of training quality is the monitoring and evaluation of training. Every training camp is visited by a supervisor who monitors whether the key parameters – eg field visits, use of materials, good seating arrangements etc were observed. This supervisor also does an end of training evaluation. Since it is difficult to train a separate evaluator, one of the trainers of the next higher step of the cascade acts as the monitor. Thus a state training team member monitors training of block teams, and a district training team member monitors the training of ASHAs.

D. Is it possible to make payments by cheque? Is it desirable?

In some areas it is difficult- but to a large extent it is possible. In the beginning there were lot of apprehensions about whether payment by account payees cheque is possible and whether it would be acceptable. Increasing experience from all the states now shows that to a large extent it is possible and even welcomed. However, be alert to the need to make exceptions and provide for a mechanism to decide on what is exceptional in the rules.

E. How does one increase timeliness and efficiency of Incentive Payment?

- The best practice for this is in Orissa. Learning from it we propose a check list – given below that outlines the steps:

a. One block level nodal person appointed.- usually a block accounts officer or block programme manager to interface with ASHAs and make the payment. If payment is being made through ANMs- the interface should be between the nodal person and the ANM.

b. Define a schedule of meetings when the ASHA would meet the nodal person. Like at the sector meeting one of the four Saturdays of the month. Or at the block office. (if it is through ANM then ANM meets the block nodal person on one day per month and the ASHA on two appointed days per month or even weekly)

c. Give the ASHA a diary where she could write down all her dues. In case of JSY, immunization day etc the service provider issues her a slip with a signature which she could submit with the diary. The ASHA brings this diary to the meeting with the nodal person/ANM.

d. The block nodal person makes all the payments she is eligible for, whichever head the payment is being made from. The payment is preferably made by cheque.

e. The block nodal person then submits the accounts to each of the divisions from whom the payment is drawn- eg JSY is from one officer, Immunisation from another, malaria work from a third etc. He also notifies what payments are due to how many ASHAs or gives a no payment due statement to the ASHA nodal officer at the district.

f. The amount of advance money to be placed with the block nodal officer for making these payments is decided on by the district nodal officer who gives him a common pool and each of the concerned programme officers who give the incentive money from the respective schemes. If some of the programmes have not given their funds- the block nodal officer could advance it from the common pool.

g. The district nodal officer reviews the programme monthly and asertains what percentage of ASHAs in each PHC area or each block have a nil dues report.

This would not be applicable for payments through the VHSCs, but one could devise similar systems for the same.

F. What is the situation of the discussion on payment of a fixed honorarium?

The case made for a fixed honorarium is that incentive payment is unreliable and uncertain and irregular, that it is the ASHAs right to get a minimum wage and that performance would improve and so would her retention which is important after so much training has been invested in her. The case made against honorarium is that it would undermine her voluntary character and she would become a worker, soon to get-unionised than remain a representative of the community. The community role could get undermined. Further it has been pointed out that the fixed sum proposed is trivial and would not make a difference and she gets much more even now as an incentive and with some more additions her earnings thus could be better. Also in a few places where a fixed sum was introduced it does not seem to have generated the benefits that is supposed to give. The decision therefore is to stick to performance based incentives.

In the long run it also depends on whether we conceive of the ASHA as slowly evolving into a full fledged service provider or remaining more of an activist and facilitator, linking with the community but providing some useful services as appropriate to the community level.

G. What is the position on accreditation? On certification?

As we move to higher levels of service provision eg use of cotrimoxazole, the use of chloroquine, the use of RDK kits, first aid provision, certification becomes more and more useful. If fixed pay is introduced and the service provider role is enhanced then better to invest more on training and certification. But for now this is not felt by most states as a priority. But some formal notification or accreditation of an ASHA – usually with an ID card so that she can receive the incentives etc is in place in most states.

It is however desirable and feasible to accredit trainers.

H. What is the institutional structure recommended for the ASHA resource center?

• ASHA Resource center is best organized as a community processes resource center which also looks after VHSC and community monitoring programmes. It is essentially a team of

consultants with a team leader. In states like Assam, Jharkhand,Uttaranchal, West Bengal it has been outsourced to an NGO. Where the NGO has been empowered to play this role- it works well. However in addition to this outsourced ARC one may need a programme management team in the SPMU.

- In other states like Chhattisgarh, Rajasthan it is a part of the SHSRC. In states like Orissa it is a part of the SPMU. Some states tried to make it a part of the SIHFW- to which there is no disagreement in principle. But it did not work out and was subsequently shifted out.

- Many states have not made an ARC and this gap can be easily seen. There is no state level material development and few evaluations or studies or evidence based decision making.

- An ARC is most needed for development of training material, for training of trainers, for concurrent evaluation, for evolution of guidelines, and for developing the programme further. It also acts as a bridge with civil society by coordinating the Asha Mentoring group. ARCs could also play an active role in programme monitoring.

I. How do we select/recruit ASHA sub-block trainers and facilitators?

- One needs a facilitator for every 20 to 30 ASHAs or about one per sector. It is the task of the facilitator to visit the ASHA, provide on the job training and support and attend the ASHA local review meetings once in two weeks. Also to help form the VHSC, facilitate its meetings, support ASHA to manage it, promote utilization of their funds and report back.

- The important criteria for a facilitator would be–should be a woman, (since most training relates to RCH areas and since they have to be visiting women in their homes); should be resident in one of the 20 to 30 villages where she is supporting ASHAs, preferably a bit centrally like in the market town, and she should have the mobility to travel to all the villages in her charge by foot or cycle plus come to the block town for review or training camps once or twice a month. A well qualified ASHA promoted to be a facilitator is a good idea for she would be very familiar with the programme. This facilitator is to be compensated at about Rs 100 to Rs 150 per day to a maximum of 20 days per month and the pay slip may specify the villages visited and the training done so that this amount is seen as training fees –on a performance basis.

J. How do we know whether an ASHA is functional or not? How does one replace a drop-out?

- This is, as mathematicians would call it – a non-trivial problem. Not easy at all. If we just leave it to the community then there could be pressure of influential sections to push out weaker sections, so as to be able to get the financial incentives. This pressure would be much more if there is a wage. If we set the bar too high or too rigidly – like the ASHA must escort the pregnant women to the hospital- that would exclude many motivated and high performance ASHAs who do not escort, simply because the escort is not needed or because they have some other work then.

- It is best to devise a set of five or six indicators and declare an ASHA

non functional only if she fails to perform on at least three of them. In addition the community must want a change. Also as far as possible the ASHA herself should suggest it. This should be checked out by local trainer and ANM independently and then only finalized. The block nodal officer maintains the official ASHA list where the change is then registered. Fix the authority for registering the ASHA thereby accrediting her to perform this role. All these steps makes it difficult to change- which is the general idea.

- Guidelines for selecting replacement ASHAs are basically similar to those for the first ASHA except that it can be implemented more rigorously. The bigger problem is how to arrange for catch- up training. An institution should be formally accredited for this purpose- and newly joining ASHAs in batches of 30 should be sent for training- all 23 days at one residential camp. In a good programme one can anticipate a 10% change every year. In a long term thinking about this programme- managing this change over should be thought through.

K. What is the role we can give to NGOs? Could we ask them to undertake the training and support at a block level? Thus, would the task of recruiting and supporting facilitators and trainers be given to them?

- It is a very good idea to outsource block level ASHA training and support to NGOs. A standard MOU for this purpose is available from the Chhattisgarh programme. The problem is that not all blocks would have such good NGOs. A mix of situations with about 25% to 33% of blocks outsourced to NGOs would have advantages. However in many states building a fair grant in aid mechanism to select NGOs and then paying them on time is not feasible. But if there is a will, there are enough best practices in this regard, based on which a workable scheme that would negotiate its way past the usual problems, could be constructed.

- Other than outsourcing block level ASHA programme support NGOs could be given the following roles:
    a. Provision of trainers for training teams.
    b. Outsourcing specific training programmes.
    c. Materials development.
    d. Evaluation studies.
    e. Social mobilization activities.
    f. Outsourcing the district resource center etc.
    g. Training panchayat members for VHSC.

L. What is the Activist role of the ASHA? To what extent is this possible? To what extent is it desirable?

- An ASHA is expected to explain to the people that health care is an entitlement, a right and not charity being done to them. That the community should hold the system accountable. An ASHA is also an activist if she recognizes that many people have reduced access to health care because they are marginalized or excluded and that she

should facilitate their access to quality care. An ASHA should see herself as a representative of the community monitoring the system more than as a link worker subordinate to the system.An ASHA should see the link between health rights and womens empowerment and work to empower women.

- It is not very possible when the same system that she has to hold accountable is the system that has to select, train, and finance her. To the extent that there are civil society partnerships with organizations who work in a rights based framework or there are sensitized officials in the leadership this could be secured to some extent. Even if these conditions are not there, the very space provided to communities to participate breaks the inertia and could empower them to move to an activist role.

- Since activist roles could lead to conflicts it is not very desirable since the ASHA would be relatively powerless in the face of the health system. Therefore the main interpretation of her activist role becomes one of reaching the unreached and of strengthening local womens organizations and womens empowerment in relation to health rights- like working with self help groups, VHSCs, panchayats etc. If she does so, often she becomes a leader and quite often she gets elected to local bodies. More than 5000 Mitanins got elected to office and they continued to be Mitanins.

- Health systems leaderships must learn to think beyond the link worker role and give her the space and support to play the activist role- the health system needs that too for change to happen.

M. The ASHA budget provides a fund for Social Mobilisation. What can it be spent on?

It is meant to be spent on meetings, rallies,kalajathas or local plays with health messages, and on events that bring people together and enthuse them about community participation and about the ASHA programme. It is a good idea to have a major mobilisational campaign before ASHA selection starts so that people can make an informed choice and also many women volunteer allowing for a choice to be made. It could be used for events related to behavior change communication – to promote desirable health behaviours.

N. What role does ASHA have in VHSCs?

- Many states have made her the member secretary of the VHSCs. This is not ideal if she has to be paid through the VHSC. However most states pay through employees and where VHSCs make payment, for that purpose others could be defined as making the decision. By making the ASHA the secretary, it is easier to build capacity in the VHSC. Even if she is not the secretary she should be a member of the VHSC. If a village has multiple ASHAs then one could either give them the post in one or two year rotation or let the village choose from amongst the ASHAs who would be the member secretary.

- ASHAs could be trained to use VHSCs to identify and reach the unreached- the most marginalized. They could also help with making and implementing village health plans.

O. Refilling Drug Kits is a huge problem? How do we organize assuming that there is no Tamilnadu type logistics system in place?

- The best answer is to get a Tamilnadu type logistics system in place. One cannot solve the problem of procurement and distribution of drugs for ASHA drug kit in isolation from the larger problem of proper procurement and distribution of all drugs.

- As an interim measure the following could be tried:

  a. Issue a stock card to the ASHA. Define for each drug, the full stock quantity that would be kept with each ASHA The drug distributing person enters the balance amount and refilled amount each month into this card. The principle of distribution is just so much drugs as to fill up to reach the full stock level.
  b. Assign a person in each block or preferably in each PHC to make the drug refill. Give him a card which notes down the distribution and stock level of each ASHA every month.
  c. The block or preferably the PHC is always provided with a three months supply of each drug based on how much was used up in the first three months.
  d. For help or a second opinion on the design of the stock cards, registers etc you could contact the state level facilitator or ASHA mentoring group member for your state.

P. What is HBNCC and IMNCI training for ASHAs? What is the choice and what is the scope and issues involved?

Both of these are approaches to train health workers for providing essential care for the sick newborn and sick child. They both offer the promise of a dramatic reduction in rural infant mortality rates. Both of these approaches provide for considerable curative care elements at the community level and then appropriate referral. For a similar level of illness, HBNCC would treat more at the local level and refer later than the corresponding IMNCI approach for it was evolved in a situation where referral support is much weaker and much of the care has to be provided at the community level. HBNCC refers to the approach developed in India in Gadchiroli, exclusively for community health workers like ASHA, and successfully replicated in many project areas. IMNCI refers to the approach being promoted by UNICEF and WHO and originally focused on ANMs and AWWs which is now being adapted and modified for ASHAs. There is a high degree of overlap between the two programmes and states like UP and Chhattisgarh have made models defined by combining both. Both programmes require substantial investment in supervision and rigor of training and done correctly are equally expensive. UNICEF provides technical support for IMNCI approaches and NHSRC is providing support for HBNCC programmes based on the Gadchiroli model (or rather NHSRC facilitates transfer of technique from its innovators to those who want to scale it up in their states as well as adapt both programmes to suit the states needs). Both programmes- IMNCI and HBNCC are approved by the government of India- with some conditions applying Evaluation studies are equivocal. The recommendation is that the choice be made in a state specific manner with respect to how much time and effort the state intends to invest in reduction of IMR and how much role it sees for the community health worker in this effort. Also if the existing resources for clinical training are completely used up in training medical officers and ANMs in IMNCI, it may make sense to develop a second system to train ASHAs at the community level with another set of resources, instead of waiting to complete IMNCI. A review of the experience of implementing IMNCI and HBNCC in different contexts would help states to make a choice.

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Section VI: Technical Assistance for the ASHA programme

The single most important step forward is the recognition of the need. Which in turn requires the sensitization that is mandatory for the state leadership to hold itself accountable to achieve the following processes

a. reach a desired number of training days per ASHA each year (12 to 28 days)
b. to prepare on a scientific basis- and not on subjective perception or whims –the focus of subsequent training programmes,
c. to ensure adequate on the job visits and follow up for each ASHA,
d. to guarantee that the ASHAs drug kit is refilled without a break,
e. to ensure that the ASHAs incentive payments are adequate and made on time
f. to build a system of monitoring the programme such that district programme managers
have data on a monthly basis which tells them how functional ASHAs have been on a few select parameters.
g. To ensure that there has been a local level meeting of sufficient quality with ASHAs every month.

This is not too much to demand- but it still remains a challenge to make administrators accountable for ensuring at least these many processes. And to sensitize programme managers at every level to understand that a failure to achieve this is not due to inherent unavoidable reasons but basically weak management capacities and skills and the lack of appreciation of design complexities.

The National and State ASHA mentoring groups and the NHSRC and state level ASHA resource centers or SHSRCs are the prime support groups to provide this assistance and guidance.

As a way of sensitization of programme managers to these essential elements of the programme and to work out the "how to" in a locale specific manner- the mentoring groups and resource centers together plan a formative evaluation that provides a feedback to managers to clarify their own understandings. Part of the problem of the ASHA programme is that everyone has his or her own theory of why and how the programme works or does not work and is very convinced of this. Formative evaluation would use their help to generate the evidence and then present the evidence back to them and let programme managers (and evaluators) realign or modify their perceptions. Hopefully this would bring the multiple understandings and expectations of this programme closer to each other.

The states should ideally create their own institutional arrangements in the form of a resource center to provide technical support. To start such institutions up and to help them grow through mutual learning the states could contact NHSRC for support. Even though NHSRC's in house capacity to provide such support is limited, it could arrange for such support from the organizations and resource persons who have experience in this area.

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